JOEL BARLOW HIGH SCHOOL
SPORTS PARTICIPATION HEALTH RECORD

This evaluation is to determine readiness for sports participation only. It should not be used as a substitute for regular health maintenance examinations. THIS SIDE MUST BE COMPLETED BY PARENT AND STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.

Name _____ Age _____ Sex _____ Grade _____ Phone _____

Address _____ Fall Sport _____ Winter Sport _____ Spring Sport _____

MEDICAL HISTORY

(to be completed by parent or guardian)

1. Do you have any allergies? (food, drugs, insect stings, etc.)
   YES ____ NO ____ List: _____
2. Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally)
   YES ____ NO ____ List: _____
3. Are you presently being treated for any condition by a physician or other health care professional?
   YES ____ NO ____ Explain: _____
4. Have you ever been advised by a doctor not to participate in any sport?
   YES ____ NO ____ Explain: _____
5. Do you have any chronic conditions, disorders or diseases?
   YES ____ NO ____ if yes, check those applicable:

Asthma ____	Bleeding Disorders ____	Diabetes ____
Epilepsy (seizures) ____	Hepatitis (liver disease) ____	Sickle Cell Anemia ____
Hypertension (high blood pressure) ____	Mononucleosis ____ year _____	Kawasaki's Disease ____
Handicap (describe) _____	Other _____	

Please check where applicable if you have or have had any of the following:

YES	NO		YES	NO
____	____	Head injury, concussion, or been unconscious If yes, how many times _____	____	____
____	____	Headaches more than once a week	____	____
____	____	Lack of feeling or numbness in any part of the body	____	____
____	____	Heat exhaustion or heat stroke	____	____
____	____	Difficulty running ½ mile without stopping	____	____
____	____	Chest pain, dizziness or passing out during exercise	____	____
____	____	Coughing, wheezing or gasping for breath with exercise or cold weather	____	____
____	____	Smoke cigarettes or chew tobacco	____	____
____	____	Heart problem, murmur or arrhythmia	____	____
____	____	Family member with a heart attack under age 50	____	____
____	____	Loss or gain of more than 10 lbs. in last year	____	____
____	____	Special diet for medical reasons	____	____
		For female participants:		
____	____	Absent or irregular monthly periods	____	____
____	____	Disabling cramps with your menstrual periods	____	____
		Eye injury or retinal detachment	____	____
		Blurred vision or vision in one eye only	____	____
		Wear glasses or contact lenses	____	____
		Hearing loss or impairment in one or both ears	____	____
		Tubes in ears or a perforated eardrum	____	____
		False teeth, caps or braces	____	____
		Nose bleeds for no reason	____	____
		Bruising easily or taking a long time to stop bleeding when cut	____	____
		Diarrhea more than once a week	____	____
		Black or bloody bowel movements (stools)	____	____
		Kidney disease or dark, brown or bloody urine	____	____
		Less than 2 kidneys or, in males, 2 testicles	____	____
		Lump(s) in armpit or groin	____	____
		Rash or skin problem	____	____
		Neck or spine or low back injury or pain	____	____

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones, joints or muscles?

☐ Head ☐ Neck ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Chest ☐ Ankle ☐ Foot
☐ Back ☐ Hip ☐ Thigh ☐ Knee ☐ Shin / Calf

Please describe all items checked above including the year the injury occurred: _____

_____

_____

_____

STUDENT AND PARENT OR GUARDIAN: We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

_____ _____ _____

Student Signature Date Parent or Guardian Signatur

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATURITY (TANNER STAGE)	1 2 3 4 5	

HEIGHT _____ WEIGHT _____

BLOOD PRESSURE _____ PULSE _____

HCT / HGB _____

URINALYSIS: _____Protein _____Blood _____Glucose

VISUAL ACUITY: _____RIGHT _____ LEFT

CORRECTED TO: _____RIGHT _____ LEFT

HEARING: _____

BODY FAT (Optional) - _____ %

CHOLESTEROL (Optional) - _____

LAST TETANUS BOOSTER Date: _____

LAST MEASLES (MMR) BOOSTER Date: _____

OTHER IMMUNIZATIONS Date: _____

SUMMARY: _____

ORTHOPEDIC EXAM

MUSCULOSKETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH AND FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS / HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

RECOMMENDATIONS

WEIGHT LOSS / GAIN _____

STRENGTHENING _____

STRETCHING _____

CONDITIONING (Endurance) _____

MEDICATION(S) _____

SPECIAL EQUIPMENT _____

BRACING / TAPING _____

I certify that on this date I have examined this student and that on the basis of the examination requested by school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

_____

_____

_____ M.D. _____ _____

SIGNATURE OF MEDICAL DOCTOR DATE OF EXAM ** MEDICAL DOCTOR / PRINT OR STAMP NAME & ADDRESS